

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amendment)

907 KAR 1:030. Home health agency services.

RELATES TO: KRS 216.935, 216.936, 216.937, 216.9375, 216.939[205.520], 42 C.F.R. 440.70, 447.325, 484.4, 45 C.F.R. 164.316, 42 U.S.C. 1396a-d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the coverage provisions and requirements relating to Medicaid Program home health care services.

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designee.

(2) "Electronic signature" is defined by KRS 369.102(8).

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Home health agency" or "HHA" means:

(a) An agency defined pursuant to 42 C.F.R. 440.70(d); and

(b) A Medicare and Medicaid-certified agency licensed in accordance with 902 KAR 20:081.

(6) "Home health aide" means a person who meets the home health aide requirements established in 902 KAR 20:081.

(7) "Licensed practical nurse" or "LPN" means a person who is licensed in accordance with KRS 314.051.

(8) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(9) "Medical social worker" means a person who meets the medical social worker requirements as established in 902 KAR 20:081.

(10) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(11) "Nursing service" means the delivery of medication, or treatment by a registered nurse or a licensed practical nurse supervised by a registered nurse, consistent with KRS Chapter 314 scope of practice provisions and the Kentucky Board of Nursing scope of practice determination guidelines.

(12) "Occupational therapist" is defined by KRS 319A.010(3).

(13) "Occupational therapy assistant" is defined by KRS 319A.010(4).

(14) "Physical therapist" is defined by KRS 327.010(2).

(15) "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy services and related duties as assigned by the supervising physical therapist.

(16) "Place of residence" means, excluding a hospital or nursing facility, the location at which a recipient resides.

(17) "Plan of care" means a written plan which shall:

- (a) Stipulate the type, nature, frequency and duration of a service; and
- (b) At least every sixty (60) days, be reviewed and signed by a HHA staff person and physician, advanced practice registered nurse, or physician assistant~~[and HHA staff person at least every sixty (60) days]~~.
- (18) "Provider" is defined by KRS 205.8451(7).
- (19) "Qualified medical social worker" means a person who meets the qualified medical social worker requirements as established in 902 KAR 20:081.
- (20) "Qualified social work assistant" means a social work assistant as defined in 42 C.F.R. 484.4.
- (21) "Recipient" is defined by KRS 205.8451(9).
- (22) "Registered nurse" or "RN" is defined by KRS 314.011(5).
- (23) "Speech-language pathologist" is defined by KRS 334A.020(3).
- (24) "Speech-language pathology assistant" is defined by KRS 334A.020(8).

Section 2. Conditions of Participation. (1) In order to provide home health services, a provider shall:

- (a) Be an HHA; and
- (b) Comply with:
 - 1. 907 KAR 1:671;
 - 2. 907 KAR 1:672;
 - 3. 907 KAR 1:673;
 - 4. All applicable state and federal laws; and
 - 5. The Home Health Services Manual.
- (2)(a) A home health provider shall maintain a medical record for each recipient for whom services are provided.
- (b) A medical record shall:
 - 1. Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service;
 - 2. Contain a copy of the plan of care;
 - 3. Document verbal orders from the physician, advanced practice registered nurse, or physician assistant, if applicable;
 - 4. Except as established in paragraph (d) of this subsection, be retained for a minimum of five (5) years from the date a covered service is provided or until any audit dispute or issue is resolved beyond five (5) years;
 - 5. Be kept in an organized central file within the HHA; and
 - 6. Be made available to the department upon request.
- (c) The individual who provided a service shall date and sign the health record on the date that the individual provided the service.
- (d) 1. If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (b)4. of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.
- 2. In the case of a recipient who is a minor, the recipient's medical record shall be retained for three (3) years after the recipient reaches the age of majority under state law or the length established in paragraph (b)4 of this subsection or subparagraph 1 of this paragraph, whichever is longest.
- (3) A provider shall comply with 45 C.F.R. Part 164.
- (4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.
- (b) Failure to return a payment to the department in accordance with paragraph (a) of this sec-

tion may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

Section 3. Covered Services. (1) A home health service shall be:

(a) Prior authorized by the department to ensure that the service or modification of the service is medically necessary and adequate for the needs of the recipient;

(b) Provided pursuant to a plan of care; and

(c) Provided in a recipient's place of residence.

(2) The following services provided to a recipient by a home health provider who meets the requirements in Section 2 of this administrative regulation shall be covered by the department:

(a) A nursing service which shall:

1. Include part-time or intermittent nursing services; and

2. If provided daily, be limited to thirty (30) days unless additional days are prior authorized by the department;

(b) A therapy service which shall:

1. Include physical therapy services provided by a physical therapist or a physical therapist assistant who is under the supervision of a physical therapist;

2. Include occupational therapy services provided by an occupational therapist or an occupational therapy assistant who is under the supervision of an occupational therapist;

3. Include speech-language pathology services provided by a speech-language pathologist or a speech-language pathology assistant who is under the supervision of a speech-language pathologist;

4. Be provided pursuant to a plan of treatment which shall be developed by the appropriate therapist and physician, advanced practice registered nurse, or physician assistant;

5. Be provided in accordance with 907 KAR 1:023; and

6. Comply with the:

a. Physical therapy service requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is a physical therapy service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is a physical therapy service provided to a child;

b. Occupational therapy requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is an occupational therapy service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is an occupational therapy service provided to a child; or

c. Speech-language pathology service requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults if the service is a speech-language pathology service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the service is a speech-language pathology service provided to a child;

(c) A home health aide service which shall:

1. Include the performance of simple procedures as an extension of therapy services, personal care, range of motion exercises and ambulation, assistance with medications that are ordinarily self-administered, reporting a change in the recipient's condition and needs, incidental household services which are essential to the recipient's health care at home when provided in the course of a regular visit, and completing appropriate records;

2. Be provided by a home health aide who is supervised at least every fourteen (14) days by:

- a. An RN;
- b. A physical therapist, for any physical therapy services that are provided by the home health aide;
- c. An occupational therapist, for any occupational therapy services that are provided by the home health aide; or
- d. A speech-language pathologist, for any speech-language pathology services that are provided by the home health aide; and
- 3. Be a service that the recipient is either physically or mentally unable to perform;
- (d) A medical social service which shall:
 - 1. Be provided by a qualified medical social worker or qualified social work assistant; and
 - 2. Be provided in conjunction with at least one (1) other service listed in this section;
- (e) A supply listed on the Home Health Schedule of Supplies, which shall be covered if provided to a recipient pursuant to the recipient's plan of care; or
- (f) A supplemental nutritional product listed on the Home Health Schedule of Supplies, which shall:
 - 1. Be ingested orally or delivered by tube into the gastrointestinal tract;
 - 2. Provide for the supplemental nutrition of a recipient; and
 - 3. Require a completed MAP-248 signed by a physician, advanced practice registered nurse, or physician assistant certifying the medical necessity of the supplemental nutritional product.

Section 4. Limitations and Exclusions from Coverage. (1) A domestic or housekeeping service which is unrelated to the health care of a recipient shall not be covered.

(2) A medical social service shall not be covered unless provided in conjunction with another service pursuant to Section 3 of this administrative regulation.

(3) Supplies for personal hygiene shall not be covered.

(4) Drugs shall not be covered.

(5) Disposable diapers shall not be covered for a recipient age three (3) years and under, regardless of the recipient's medical condition.

(6) Except for the first week following a home delivery, a newborn or postpartum service without the presence of a medical complication shall not be covered.

(7) A recipient who has elected to receive hospice care shall not be eligible to receive coverage under the home health program.

(8)(a) There shall be an annual limit of twenty (20):

1. Occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection;

2. Physical therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection; and

3. Speech-language pathology service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limits established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered

during the same time period.

(2) For example, if a recipient is receiving a speech-language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for a speech-language pathology service provided to the same recipient during the same time period via the home health services program.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

Section 8. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeal Rights. (1) An appeal of an adverse action taken by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

Section 11. Incorporation by Reference. (1) The following material is incorporated by reference:

- (a) "MAP-248", July 2021~~[April 2009]~~;
- (b) "Home Health Services Manual", May 2014;
- (c) "Technical Criteria for Reviewing Ancillary Services for Adults", February 2000;
- (d) "Technical Criteria for Reviewing Ancillary Services for Pediatrics", April 2000; and
- (e) "Home Health Schedule of Supplies", May 2014.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at:

(a) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday 8 a.m. to 4:30 p.m.; or

(b) The Web site located at <https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/hh.aspx> [<http://www.chfs.ky.gov/dms/incorporated.htm>].

LISA D. LEE, Commissioner

ERIC C. FRIEDLANDER, Secretary

APPROVED BY AGENCY: August 28, 2021

FILED WITH LRC: September 8, 2021 at 8:00 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on November 22, 2021, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by November 15, 2021, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until November 30, 2021. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Specialist, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-6746; fax 502-564-7091; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding home health services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Medicaid Program coverage provisions and requirements regarding home health services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding home health services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding home health agency services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendments to the administrative regulation will comport with recent legislative and practice evolution that allow for advanced practice registered nurses (APRNs) and physician assistants (PAs) to order services to recipients receiving services from home health agencies. Specifically the administrative regulation is amended to allow for an APRN, a PA, or a physician to sign a plan of care, or certify the medical necessity of modifications to a plan of care. In addition, the MAP-248 form is updated in order to allow for an APRN, PA, or a physician to authorize services.

(b) The necessity of the amendment to this administrative regulation: Amending this administrative regulation is necessary to expand the practice of APRNs and PAs within home health agencies, especially within fee-for-service Medicaid.

(c) How the amendment conforms to the content of the authorizing statutes: The amendments to the administrative regulation will comport with recent legislative and practice evolution that allow for advanced practice registered nurses (APRNs) and physician assistants (PAs) to order services to recipients receiving services from home health agencies.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: SB 154 from the 2021 Regular Session allowed for additional practice by APRNs and PAs within home health agencies. In addition, this has been an ongoing topic and potential area of expanded practice for some time.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are currently approximately 90 home health services providers enrolled in Medicaid.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No action is required of regulated entities or individuals.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on regulated entities or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Home health agencies will benefit by being able to utilize other providers in providing home health agency services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS does not anticipate additional expenses in administering this administrative regulation as a result of this amendment on an initial basis.

(b) On a continuing basis: DMS does not anticipate additional expenses in administering this administrative regulation as a result of this amendment on a continuing basis.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fee nor funding increase is necessary to implement the administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The administrative regulation neither establishes nor increases any fee.

(9) Tiering: Is tiering applied? Tiering is not applied as the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.220.

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Noth-

ing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. Medicaid programs are required to cover “home health services (§440.70) to any individual entitled to skilled nursing facility services.”

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 440.220.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not anticipate that this administrative regulation and amendment will generate additional revenue in the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS does not anticipate that this administrative regulation and amendment will generate additional revenue in subsequent years.

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment in the first year.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional cost as a result of the amendment in the first year.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): _____

Expenditures (+/-): _____

Other Explanation: